TACKLING THE
Tough Questions

Drug-Eluting Stents
Stem Cell Research
Integrative Medicine
Alzheimer's
HIV Professionalism
Obesity Cancer

JEFFERSON MEDICAL COLLEGE • THOMAS JEFFERSON UNIVERSITY • SUMMER 2007
The estimated annual costs of care of Alzheimer’s disease — including direct medical costs and associated loss of wages and productivity — is $100 billion. And more than five million people in the United States are living with it. At the Farber Institute for Neurosciences, our doctors are developing promising new drug therapies to lessen the effects of this disease.

The American Cancer Society estimates that over the course of their lifespan, women have a one in three chance of contracting cancer; in men, it’s 50 percent. Researchers at the Kimmel Cancer Center at Jefferson investigate the genetics of cancer in order to treat individuals more effectively, while clinicians work to improve screening procedures and preventive services to decrease the cancer risk in our local population.

Over 25 percent of the adult population is obese and the numbers in our juvenile population are equally alarming (nearing 20 percent). The associated health risks include hypertension, type 2 diabetes, coronary heart disease, and stroke to name only a few. According to a study of national costs attributed to both overweight and obesity, annual medical expenses may have reached as high as $78.5 billion. At Jefferson, doctors at the Center for Excellence in Obesity Research are teaching members of our local population to make healthier food choices because even modest weight loss has been shown to decrease risk factors.

One of the few areas where we have made real progress is in cardiac care. Heart disease, heart attack, and high blood pressure no longer kill as many people as they once did. Cardiovascular disease is still significant, but progress has been made with an across-the-board approach to care — monitoring blood pressure, treating blood pressure early, and maintaining control in asymptomatic patients. The focus now in cardiac care has moved to heart failure and cardiac arrhythmias. The answer to this threat is not to create heart transplant programs in every hospital. The answer has to be focused on those things that have a huge effect on a large population at a much lower cost.

But here at Jefferson, our doctors also address healthcare costs through innovative directions in clinical care delivery. By offering classes, screenings, and other outreach programs throughout the region, Jefferson’s presence makes a real difference to the people in our community. Measuring and improving results across the spectrum and life cycle of diseases, our doctors work to drive down healthcare costs. Our new electronic medical records will ensure the coordination of services and ultimately enhance patient care. Our plan to consolidate many of the practices now scattered around our campuses in a new ambulatory care facility will enable patients to go to a single location to access the care providers, diagnostic tools, and therapeutic modalities necessary to treat their conditions.

Improved access to healthcare improves patient outcomes. Developing the quality of our professionals, services, technologies, and facilities will positively impact the people in our region, in every area served by Jefferson.

The challenge for today’s physician is to balance prevention with acute care and cost with value. We must look for more cost-effective approaches to diagnosis as opposed to using only the most expensive new technologies. We must find ways to deliver high-quality care within a shrinking healthcare budget — which is destined to shrink even more. We must discover the means to ensure that the population is cared for in these critical areas because of the impact these diseases have on the availability of resources for the entire system.

Sincerely,

Robert L. Barchi, MD, PhD
President
Thomas Jefferson University
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Before I go a single step further, I would like to thank all of you who have communicated with me about the 101 Club. Hundreds of generous individuals have sent a check for $101 to me based on the story I related to you in the fall issue of this Alumni Bulletin. Equally important to me, a number of you have indicated that this story has “brought you back” to Jefferson, after years of “estrangement.” For some, the estrangement began while you were at Jefferson. Your comments, some of them very moving, have provoked me to thought. It is this estrangement that I would like to address and try in some small way to repair.

When I think of estrangement the synonyms that come to my mind include rupture, rift, or alienation. For some, an event or an interchange with the college that occurs for someone who previously was “attached” or emotionally linked with the college may have created a rift or a rupture of that relationship. As an example, this may surface in the significant desire for an offspring to be accepted at Jefferson. The rupture may result from the inability to gain acceptance, or it may result from poor communications from the college around that individual’s inability to be accepted. Certainly in the latter case, the college and I bear some responsibility for that schism. Over the past few years, precipitated by exactly that kind of event, which occurred with a truly loyal and attached alumnus and his daughter, we have worked very hard to improve that communication. While I have personally apologized to the individual involved, it has bothered me on two levels. The first is that the event happened. The second is the recognition that if it happened once, it has likely happened more than once. Thus, we need to acknowledge that we may have failed in other instances and work hard to prevent it from happening again. So, I would ask you to be sure that if a relative of yours applies for admission to Jefferson, that they note on their application that they are related to you and let Dr. Clara Callahan, dean of admissions, or me know by e-mail, letter, or phone that there is a family application being submitted. While this will not guarantee admission, it will assure individual review of the application and uphold our commitment to all legacy applicants.

The more difficult estrangement for us to address is alienation. I say this because I believe that many recent Jefferson graduates feel alienated, having never developed a bond with our institution. I differentiate this from those who suffer from a rift or a rupture due to an event, such as the one noted earlier, or a circumstance such as the sale of The Gross Clinic. Certainly the latter created a discordance with a significant number of alumni, faculty, and students. These kinds of rifts will be healed by the cautery of conversation and the tincture of time for some of us, but not for others. All one can do is explain the reasons behind the decisions and be open to understand diverse points of view.

These are not, however, the personal hurts that may be seen in the student who left Jefferson unhappy with or upset by their medical school experience. Over the years, I have tried to understand why students are disenchanted by medical school. This is not an idle preoccupation. You see, I believe that the physician who leaves medical school alienated may also have developed other reactions to their medical education that will “shape” them as clinicians and individuals. The cynicism that one may develop, for example, would not be confined to negative thoughts of their nephrology attending (choosing me as an example), but potentially develop into a cynical approach to the world of medicine. Since our goal is the training of outstanding, humanistic physicians whose lives and potential are fulfilled through service to others, these views, perspectives,
and coping mechanisms are maladaptive to our goal.

One reason for the development of alienation would be that the student failed to reach his or her own goals, and either appropriately or inappropriately ascribe blame to an individual faculty member or the school as a whole. I think that these are the minority of our alienated graduates. I say this because the vast majority of our students obtain residency programs in the discipline and training environment of their choice, at one of their top three choices. The vast majority of our students become board certified in their chosen specialties and subspecialties and pursue meaningful careers. So the “measurable outcomes” of their medical educational program are generally very positive.

I think the issue goes much deeper than the formal educational program. My belief, based on nothing but 26 years in medical education (15 years as a faculty member at Jefferson and seven years as its dean) is that we failed to treat our medical students as young colleagues from the day they arrived on campus. Rather, students were reared as mushrooms, kept in the dark and fed large doses of detritus until they matured, and then were brought into the light of day at graduation. And, while the bright, motivated, and diligent medical students adapted and survived, they were changed by the way they were treated during the educational process. For some the change was either neutral or positive, but for many, the impact was decidedly negative. It is no wonder that some felt alienated. Furthermore to the extent that most or all students had negative experiences, the alienated population grows.

For many students, the cognitive dissonance between espousing empathy and compassion, all the while failing to recognize the impact of our curriculum on the emotional well-being or health of our students, is striking. The cognitive dissonance of espousing respect and integrity, while treating students in a belittling or demeaning fashion or overtly harassing them in some fashion, bespeaks of abuse not mentoring. And finally, the cognitive dissonance of the articulated goal of producing humanistic physicians, while treating them in a non-humanistic fashion, can drive one to cynicism or despair.

There is much disillusionment available to those who enter medicine, based purely on the reality of medicine versus the idealized view they may hold upon entry into medical school. But, the reality of medicine is framed by the glasses one wears, and the faculty are the fashioners of our students’ spectacles. Treatment of our students, from the moment they enter our doors as colleagues on the same journey, is a major component in framing their future. Teaching them not only the facts required to, as Aristotle said, “know the good,” but also modeling for them the “motivation to do the good, even at risk to oneself” in order to “produce good in all our actions,” is what we must be about. This is the Aristotelian view of the “good or virtuous person,” or in our profession the “virtuous physician.” Giving them both the tools to do good, as well as nurturing the motivation to do good from the start of medical school is what we aim to accomplish.

Does this work? Well, I think it does, and let me give you an example from the current Introduction to Clinical Medicine coursework for second-year students. A class was invited to watch a film then sit in small groups to discuss the impact of the film on them as individuals. The film was the story of a young physician who developed, and ultimately died of, a synovial cell sarcoma. It was a moving piece produced by Ruth Drazen, who was also the producer of The Choice is Yours, about the life and philosophy of Victor Frankl, which we use as a discussion trigger concerning death, dying, and the meaning of life, in the first year.

There are a number of aspects of this event that are striking. First, the auditorium was filled with both students (essentially 100 percent attendance) and faculty (about 40 faculty members). Second, you could have heard a pin drop throughout the showing of the film, save the occasional tearful sniffle. Finally, the faculty and the students sitting together were tremendously affected by what unfolded on the screen. The faculty, by being who they are, demonstrated that they were equally affected by the film and shared their thoughts and reflections with their students in small group discussions. This is a community of teachers and learners, all enlightening each other regardless of station in the hierarchy.

And, you should know that events such as these are no longer a rarity on our campus. The faculty genuinely enjoy being with the students, and the students relish time with the faculty.

In 2001, about nine months after I became dean, I wrote the following in the Examiner. It spoke of my vision and dream for Jefferson:

Thomas J. Nasca, MD’75, MACP

I believe that many recent Jefferson graduates feel alienated, having never developed a bond with our institution.

continued on following page
The missing ingredient is that a Premier Medical School is a place that everyone wants to be, not just be from. The environment is stimulating, the collaboration extensive, and there is an excitement in these places that draws students and faculty like a magnet. Were we to achieve individual, and even collective excellence without dealing with the Culture of Jefferson, we would not achieve our Vision. If we aspire to be a Premier Medical School, then we must change the way we work with each other, the way we treat each other, and the way we nurture our students, young physicians, and junior faculty. We must embrace and enhance our diversity while celebrating our similarities. We must move away from what is currently perceived by many as a “pejorative, evaluative environment” for our students, and an environment of benign neglect, or “sink or swim” for our young physicians, post-doctoral fellows, and junior faculty. We must evoke to a Collegial Teaching and Learning Environment, one marked not only by a commitment to excellence, but also of commitment to each other, to feel the responsibility to assist each other in the achievement of excellence. This environment actually is the fullest development of the values of professionalism in medicine and medical science.

Altruism, the core value of professionalism, doing the right thing for the right reason even at risk to oneself, should permeate our daily lives. Compassion, empathy, integrity, and honesty are attributes of the professional, which are not turned on and off at a whim. They are a way of life — one that should start the day one arrives in medical school or graduate school, and which should guide our actions each and every day throughout our careers. If we intend to inculcate these values to be demonstrated from day one by our students, residents, and faculty. Indeed, we must nurture the development of behaviors based on these values and design systems of education, research, patient care, and community service that foster their fullest expression.

We are not yet the premier medical school that I wrote of, but we are, I believe, much closer. We are much more of a collegial teaching and learning environment today than I have seen in any institution I have had the opportunity to visit. We have a core of faculty who care deeply and are personally invested in the growth and success of each of our students. They are both willing and able to model the values of our profession. We have a core of young and older deans who see their success in the eyes of their students, and a cadre of outstanding students who aspire to greatness in lives of service to mankind. We have a graduating class that would highly recommend Jefferson to the next generation of future physicians. And, in case you might be concerned that they are happy but not learning, well, you can see that their USMLE Step 1 scores indicate that, relative to their peers across the country, they are a “cut above.”

I relate this to you because the amelioration of the alienation from Jefferson that many of us feel cannot occur with first-hand experiences, unless the second-hand experiences of our current students and faculty open the door to bring us back. You must take pride in the work we do and comfort in knowing that what might have been missing in your experience is present for the next generation of Jefferson physicians. And you must trust that, as one alumnus recently said in a note that accompanied his $101 check, “There is at least one person with a heart at Jefferson.”

I can assure you, there is a legion of faculty, staff, and students with hearts that would make you proud. We hope to see you back with us, soon.

Sincerely,

Thomas J. Nasca, MD'75, MACP
The Anthony F. and Gertrude M. DePalma Dean, Jefferson Medical College
Professor of Medicine and Molecular Physiology and Biophysics
Your space for letters to the editor doesn’t allow room for me to fully express my concerns for our present healthcare system or my overwhelming approval of the message contained in the President’s letter and the Dean’s column in the spring Bulletin. The patient has been forgotten and medicine is ruled by nonprofessionals to the detriment of the entire system. Subspecialists are needed as consultants, but every patient needs a primary physician to see the whole person, coordinate his/her care and patients must have an active role in their care.

I have forwarded copies of these articles to the EVP of the AAFP. Dr. Henley was impressed and plans to distribute them to many of the officers of the academy. I hope and pray that the new curriculum will be successful for the sake of our patients, our profession, and our healthcare system.

George Wolff, MD’52
Greensboro, NC

Send your letters to: Editor, Alumni Bulletin, Jefferson Medical College of Thomas Jefferson University, 925 Chestnut Street, Suite 110, Philadelphia, PA 19107-4216 or via our web site at: www.jefferson.edu/jmc/alumni/bulletin.cfm
Scientists at the Center for Translational Medicine have staved off heart failure in animals by using gene therapy to shut down the adrenal gland’s excessive output of fight or flight hormones such as epinephrine and norepinephrine. By blocking GRK2-G protein-coupled receptor kinase 2, an important regulatory enzyme, they cut the hormone production that forces the heart to pump too hard, leading to heart failure. Such a novel approach — targeting the adrenal gland in addition to the heart — provides a potential new strategy against heart failure and could lead to a new class of drugs.

The researchers, led by Walter Koch, PhD, W.W. Smith Professor of Medicine and director of the Center for Translational Medicine, reported their findings in the journal *Nature Medicine*.

"The emphasis has always been in treating right at the heart," comments Stephen B. Liggett, MD, director of the cardiopulmonary genomics program at the University of Maryland School of Medicine. "Despite our best efforts, about half of all heart-failure patients die within five years of diagnosis, so clearly something new is needed. These results add a completely new dimension to the way physicians might be able to intervene to improve heart-failure therapy.”

When an individual’s heart begins to fail, the sympathetic nervous system, attempting to compensate for the weakened heart, goes into overdrive, pumping out increased levels of stimulants (catecholamines) making a bad situation worse. The typical treatment — beta blockers — inhibits the beta adrenergic receptors on the heart, blocking the hormones that force the heart to work overtime.

Koch’s group focused instead on the source of catecholamines — the adrenal gland. They discovered that in heart failure, the extra hormones “desensitize” the adrenal’s alpha 2 adrenergic receptors because of a rise in GRK2, essentially turning them off. Using gene therapy to block adrenal gland GRK2 in animals with heart failure, the scientists were able to get the alpha 2 receptors working again and found that the beta adrenergic receptors on the heart worked better as well.

“We’ve shown that in the adrenal gland, resetting the alpha adrenergic receptors by inhibiting GRK2 causes more normal regulation and feedback control, and catecholamines are lowered,” says Koch, who also heads the George Zallie and Family Laboratory for Cardiovascular Gene Therapy. “If less catecholamine is presented to the heart, then the beta receptors restabilize, improving heart function. The heart is allowed to relax and get better.”

“This is the first time anyone has identified a molecular mechanism involved in such sympathetic overdrive in heart failure,” adds Anastasios Lymperopoulos, PhD, a postdoctoral fellow at the center. The adrenal gland, GRK2, then becomes a new target for heart-failure medications.
Rabies-based Vaccine Could Be Effective Against HIV

Rabies may hold a key to defeating HIV. Using a drastically weakened rabies virus to ferry HIV-related proteins into animals, scientists have essentially vaccinated them against an AIDS-like disease. Early evidence indicates that the vaccine, which does not protect against infection, prevents the development of the disease.

Reporting in the *Journal of Infectious Diseases*, Jefferson scientists showed that two years after the initial vaccination, four non-human primates were protected from the disease even after being “challenged” with a dangerous animal-human virus. Two control animals developed an AIDS-like disease.

Matthias Schnell, PhD, professor of microbiology and immunology, and his co-workers tested the effects of inserting two different viral proteins into the rabies virus genome, using such virus-based vaccines to prevent disease in rhesus macaques. One of these viral proteins was a glycoprotein on the surface of HIV; the other was an internal protein from simian immunodeficiency virus (SIV).

Four macaques were immunized with both vaccines, while two animals received only a weakened rabies virus. After they gave the animals an initial vaccination, they tried two different immune system boosts, but did not see enhanced immune responses. The researchers then developed a new vector, a viral surface protein from another virus, vesicular stomatitis virus (VSV). Two years after the initial immunization, they gave a booster vaccine with the rabies-VSV vector and saw SIV/HIV-specific immune responses.

The group then challenged the animals with SIV and measured various parameters of infection, such as immune system CD4 cell count, amount of virus in the bloodstream, and immune system antibody response. They found that those animals that were given the test vaccine could control the infection. The control animals without the experimental vaccine had high levels of virus and a loss of CD4 cells.

The idea was that such rabies vectors would help attract a strong response from the animal’s immune system, though the rabies virus used cannot cause the disease. These vectors are based on a type of rabies vaccine strain that has been used for more than 20 years in oral vaccines against rabies in wildlife in Europe.

“We still need a vaccine that protects from HIV infection, but protecting against developing the disease can be a very important step,” Schnell says, noting that they are not sure how long the viral immunity will last.
Albert Appointed Chair of Orthopaedic Surgery

Spine specialist Todd J. Albert, MD, has been named the Richard H. Rothman Chair of the Department of Orthopaedic Surgery. Albert is also professor of orthopaedic surgery and neurosurgery at Jefferson and president of the Rothman Institute. The Annenberg Foundation established and endowed the chair in honor of internationally renowned orthopaedic surgeon and field pioneer, Richard H. Rothman, MD, PhD. The chair, which will honor Rothman in perpetuity, will be used for orthopaedic research and research-related purposes.

In February 2007, Albert assumed the role as the James Edwards Professor and chair of the department when Rothman stepped down. Rothman will now take the title of the James Edwards Professor of the Department of Orthopaedic Surgery as he continues to pursue research and clinical interests.

Jarvik 2000 Heart Assist System Implanted

This spring, cardiac surgeons Scott Silvestry, MD, and Linda Bogar, MD, PGCT ‘04, implanted a Jarvik 2000 Heart Assist System into a 55-year-old man suffering from chronic heart failure. The advanced heart failure and cardiac transplant team at Jefferson University Hospital is the first in the state to implant the new device.

In a little more than four hours, the device helped the man’s heart resume normal blood flow. Rather than take over for the biological heart, the Jarvik 2000 Heart Assist System augments the weakened heart’s blood output to help restore a normal flow throughout the body. The system is the smallest and simplest left ventricular assist device available. It is about the size of a C battery and fits directly inside the heart’s left chamber.

“The Jarvik 2000 Heart Assist System is the next generation of assist devices — a smaller, more durable pump that is implanted directly into the left heart ventricle,” explains Silvestry, surgical director of the heart transplant program. “This smaller assist device was implanted without the use of the heart-lung machine through an incision in the left chest. It enables us to provide a less invasive option for use in BTT indication — bridge to transplant — to help patients to become stronger and in better physical condition for a new heart.”

Members of the Jefferson Advanced Heart Failure and Cardiac Transplant Center who were involved include: Silvestry, who is also assistant professor of surgery; Paul Mather, MD, associate professor of medicine; Bogar, transplant surgeon and assistant professor of surgery; Linda Sundt, MD’74, clinical assistant professor of anesthesiology; and James Diehl, MD, clinical professor of surgery and director of the division of cardiothoracic surgery.

Increased Empathy in Medical Education Essential

A paradigm shift in medical education is needed, one with more emphasis on training future physicians to enhance their empathy skills and to learn to view patients as persons, not just cases, medical education specialist Mohammadreza Hojat, PhD, says.

“If we want to train physicians with more empathy, then education must shift from emphasizing only the biomedical to providing a biopsychosocial framework with a more complete picture of patients as persons,” says Hojat, research professor of psychiatry and human behavior.

According to Hojat, author of Empathy in Patient Care: Antecedents, Development, Measurement, and Outcomes, medical education today emphasizes the biomedical paradigm of health and illness, which is akin to treating an organ affected by disease rather than curing a patient’s illness. “The thinking is, once you treat the organ, the patient is fine,” he says. “This is a unidimensional approach to patient care. Health is not simply defined as absence of disease — it encompasses the physical, mental, and social well-being of a person.”

His book, aimed at physicians, medical students, residents, psychologists, clinical social workers, and others involved in patient care, serves as a platform to discuss factors that contribute to empathy development, such as genetic, social, and educational aspects and approaches. Hojat is convinced that a caregiver’s empathy skills can influence how a patient fares. “It’s important to consider the potential role of empathic ability in clinical outcome,” he says. “When the patient feels the physician understands him or her that, in itself, seems to have a therapeutic effect.
“Medical schools are eager to teach professionalism in the practice of medicine,” he continues. “Empathy is an important element of professionalism because of the increased attention to the physician-patient relationship.” Still, despite advances in technology and medicine, “it seems difficult to convince medical students that the art of medicine can be as important as the science.”

Many medical schools are incorporating new classes and methods into the curriculum to improve empathy skills among students and residents, hoping to help them better understand what patients experience. Some are including more courses in the arts and humanities and literature, for example, while others involve students in role-playing or shadowing a patient. Improving interpersonal skills and the interpretation of non-verbal cues are among other ways to help develop empathy skills. Says Hojat: “We need to convince medical students and residents that empathic engagement in the context of patient care leads to positive clinical outcomes, and develop a formal, targeted educational program to enhance empathy in patient care.”

Rosato Joins Surgery
Francis E. Rosato Jr., MD’99, has joined the department of surgery as assistant professor of surgery and a general surgeon following a fellowship in minimally invasive surgery at the Hospital of the University of Pennsylvania. A member of the Society of Gastrointestinal Endoscopic Surgeons, his research interests include natural orifice transgastric endoscopic surgery, epidermal growth factor receptor inhibitors for the treatment of breast cancer, gastrointestinal motility disorders, and endoluminal approaches to bariatric surgery.

First in Pennsylvania for NIH Funding in Orthopaedic Research
Jefferson ranked second in the United States and first in Pennsylvania in 2005 for orthopaedic research funding by the National Institutes of Health (NIH). The rankings are released by the NIH after the end of each fiscal year.

Upon learning of the achievement, Thomas J. Nasca, MD’75, MACP, dean of Jefferson Medical College, said, “Our funding is a testament to the longstanding commitment of the medical college and the department of orthopaedic surgery to landmark biomedical research that will translate into a leading-edge clinical practice. Under the previous leadership of Dr. Richard Rothman, and now under the direction of Dr. Todd Albert, excellence has been nurtured and supported.”

DePalma Investiture Ceremony of Drs. Nasca and Pacifici
Thomas J. Nasca, MD’75, MACP, dean of Jefferson Medical College (left), and Maurizio Pacifici, PhD, director of orthopaedic surgery (right), are pictured with Robert L. Barchi, MD, PhD, president of Thomas Jefferson University, and Gertrude M. DePalma, wife of Anthony F. DePalma, MD’29. Dr. Nasca was invested as the Anthony F. and Gertrude M. DePalma Dean of Jefferson Medical College, while Dr. Pacifici was named the first holder of the Anthony F. and Gertrude M. DePalma Professorship of Orthopaedic Research. The ceremony, which was held on April 12, honored the legacy of the late Dr. DePalma, as well as the two honorees.
The ongoing collaboration between Jefferson's distinguished international team of scientists and the exceptional clinicians of the Rothman Institute at Jefferson results in highly and rapidly translational investigations. Current areas of funded research activity include: development of technology for infection-free orthopaedic implants; transplantation of adult stem cells to restore degenerate intervertebral disks; regulation of skeletal growth and repair by environmental factors; causes of developmental skeletal anomalies and prevention of excessive bone deposition; and maintenance of joint function and treatment of osteoarthritis.

Hamilton Building Update

October 15, 2007, has been set for the completion of the Dorrance H. Hamilton Building. Two days of opening ceremonies and celebrations are scheduled for October 18 and 19. Festivities include a donor reception, ribbon cutting, lecture, and tours. For more information, contact Fritz Ruccius at 215-955-8733 or frederick.ruccius@jefferson.edu. You can check the construction’s ongoing progress by visiting www.jefferson.edu.

Portrait Presentation to Berg

The class of 2007 overwhelmingly voted Dale Berg, MD, associate professor of medicine, as this year’s portrait recipient. Students based their decision on “his enthusiasm to teach, his assiduous dedication to our class, and his inspiring passion for medicine.” In the words of one student, “No one brings more enthusiasm, excitement, and experience when he teaches. It is clear that Dr. Berg absolutely loves what he does, which is quite inspiring for students.” Another student remarked, “Dr. Berg deserves this recognition because he is one of the most engaging and receptive clinical faculty members we have. He treats each student as a colleague, with the utmost respect and empathy. His enthusiasm for practicing and teaching medicine is unmatched. Dr Berg’s sense of humor is a shining example of living life with joy.”

Each year the graduating class chooses a faculty member to have their portrait painted as a testament to the class’s appreciation of their teacher’s commendable dedication to medical education.
Although continuing medical education is mandatory for all physicians, sometimes busy MDs find it difficult to discover what is new outside of their own particular fields of expertise. Or, like most Americans, they hear about so-called breakthroughs from the media but don’t have time to sift through the data to learn just how promising these advances are. The editorial staff of the Alumni Bulletin invited the smartest, most thoughtful, most insightful people we know — Jefferson faculty members, researchers, and alumni — to offer observations informed by scholarly expertise on some of today’s hottest medical topics.
One of the more recent trends in medical education is the “bubbling up” of the issue of professionalism in medical school curriculum. Faculty and clinicians have long understood that there is a tacit or hidden curriculum about professionalism. With attention to systems theory, medical error analysis, and the general difficulties of practicing in the current health-care environment, most medical schools have started to include the teaching of professionalism as a content topic and not rely on the assumption that students will learn to be professional by observing their teachers and mentors.

An inherent sense of professionalism is an attribute that we hope is present in every applicant to medical school. Here at Jefferson, we have been working on teaching and reinforcing professionalism longitudinally throughout the curriculum in the medical college and continuing through residency training.

Medical students begin their education in professionalism at their orientation with patient presentations and case discussions. Orientation week is capped by the White Coat Ceremony where students are welcomed into the community of physician learners by the faculty, the dean, and the president of the university. The new matriculants put on their white coats for the first time, symbolizing their entry into the medical profession.

Soon after this ceremony, first-year students begin their “Introduction to Clinical Medicine I” course, which includes a year-long study of professional development, as well as skills teaching in communication and beginning physical diagnosis. This underpinning of professionalism is continued throughout second year in the basic science courses and “Introduction to Clinical Medicine II.”

The third-year clinical clerkships focus on professionalism both in the day-to-day teaching realm of clinical inpatient and outpatient medicine and surgery and in specific teaching seminars and discussions. Discussions may be case-based or teaching modules or draw upon the students’ own experiences as clinical clerks.

Several years ago, a Curriculum Committee Task Force developed the concept of the interclerkship session, a full- or half-day teaching session on a topic in medicine that is presented to all of the third-year students, which dedicates a day to dialogue and discussion on relevant topics in medicine. One of these interclerkship sessions focuses on medical errors and another on professionalism, which is presented toward the end of the training year.

Professionalism is addressed again in the fourth-year advanced physical diagnosis course. The Rector Clinical Skills Center faculty has developed case-based instructional videos. These videos are used in student teaching, resident teaching-how-to-teach sessions, and faculty development sessions. They are also being included in workshop sessions at the national AAMC meeting this fall.

Several faculty members along with the dean are working on a book on professionalism for use by Jefferson. The book will contain case material that can be used throughout all four years of medical education.

Although it seems clear that true professionalism must evolve as an integral part of an individual’s character, we do believe that professionalism can be reinforced and “taught” in these ways. It is our responsibility as educators to nurture and encourage our students’ further development and attention to these attributes in them and in their colleagues.

Our faculty here at Jefferson and at our affiliate and far-reaching preceptor sites are enthusiastic about this process.

Karen M. Glaser, PhD, is associate dean for academic affairs/undergraduate medical education, and a faculty member in the departments of family and community medicine and psychiatry and human behavior. Glaser teaches students in the first two years and works with residents and faculty on teaching doctor-patient communication and medical education. She is currently the co-chair of the Medical Student Professionalism Task Force and the dean’s representative to the Professionalism Review Committee.
The use of complementary and alternative medicine (CAM) treatments in the United States is substantial. In 1993, *The New England Journal of Medicine* published the first national survey on the use of CAM, which revealed that one in three respondents had used an unconventional or CAM treatment in the previous year. Follow-up studies confirmed CAM use rates, and most studies suggested that people use these treatments in addition to conventional medical care. Additional reports indicated that people tend not to disclose their use of CAM treatments to their conventional physicians, with many believing that their doctors were unreceptive to the issue.

There is evidence that the tides are changing with most medical schools now offering some CAM curriculum (over 30 have a formal academic program). In addition, the National Institutes of Health (NIH) has created a National Center for Complementary and Alternative Medicine (NCCAM), which is charged with developing and funding CAM research.

Amidst growing interest by the mainstream medical community, the term “complementary and alternative medicine” is slowly being replaced by “integrative medicine.” The latter reflects an approach that unites traditional biomedicine with complementary modalities intended to enrich the overall treatment, such as acupuncture for management of chemotherapy-induced nausea, or nutritional supplements for osteoporosis. Hence, in the emerging integrative medical model, the word “alternative” is dropped completely because complementary therapies are not practiced in isolation or detached from Western biomedicine.

Jefferson is a national leader in integrative medicine with one of the few university/hospital-based integrative medical centers in the country. Jefferson’s center, the Jefferson-Myrna Brind Center of Integrative Medicine, is at the forefront of clinical care, teaching, and research in integrative medicine and has the only recognized fellowship training program. Academically, the Brind Center is part of the department of emergency medicine, and its physicians have Jefferson appointments. Jefferson medical students do elective rotations at the center throughout the academic year with many participating in research projects.

Overall, the center’s clinical model is largely consultative with an emphasis on communication and collaboration with the patient’s primary physician. This model works especially well with the center’s integrative oncology services, which are primarily intended to improve the quality of life for cancer patients.

Daniel Monti, MD, heads the Jefferson-Myrna Brind Center of Integrative Medicine, which is one of the few university-based integrative medicine centers in the country. Monti is a national expert on mind-body medicine, including the effects of stress reduction on health outcomes in cancer patients. He has received significant research funding from the National Institutes of Health (NIH)/National Cancer Institute (NCI) and was a keynote speaker on complementary medicine at the NCI’s 2006 survivorship conference.

**Pictured above:**

*Cichorium intybus* (Chicory) is a bitter herb that can be a useful aid to digestion.
Alzheimer’s disease is the most common cause of cognitive decline in adults. In the 100 years since Alois Alzheimer identified the disease, we have learned that several specific gene mutations, and possibly two common genetic variations, increase the occurrence of this neurological condition. Environmental factors, both protective and unfavorable, most likely interact with genetic vulnerability to affect risk.

Some risk factors are not modifiable, for example age and sex (women tend to be at greater risk). However, behavior, diet, and education appear to modify the risk. Regarding the latter, persons with fewer than eight years of education are 2.6 times more likely to develop Alzheimer’s than those with more education. Several studies have demonstrated that cognitive training has beneficial effects on many functional outcomes in older adults. Mentally stimulating leisure activities, such as reading and playing board games or a musical instrument, were protective. In fact, each one-point increase on a scale measuring frequency of cognitive activity reduced dementia risk by seven percent. Physical activity, such as walking, also reduces the risk. One study showed that the greater the distance walked, the lower the risk of mental decline.

Research indicates that diets rich in omega-3 fatty acids (docosahexaenoic acid found in fish), folate, antioxidants (vitamins C and E), and moderate consumption of alcohol help lower risks. The Nurses’ Health Study showed that women over age 60 who drank a daily glass of beer, wine, or its equivalent in liquor, had better cognitive skills than nondrinking women and were less likely to decline cognitively over time.

By contrast, high intake of copper and fat accelerate mental decline. Moreover, obesity, hypertension, hypercholesterolemia, insulin resistance, and adult onset diabetes mellitus all increase risk. Some, but not all, epidemiological studies suggest that statin and nonsteroidal anti-inflammatory drugs lower incident occurrences. Interestingly, psychological distress, social isolation, and loneliness also increase the probability of developing the disease.

Clearly, Alzheimer’s is a complex disorder involving linkages between one’s genes, cardiovascular health, and related behavioral and medical risk factors. Understanding these relationships may reveal ways to preserve optimal cognitive function or prevent and thereby delay the onset of Alzheimer’s disease.

A note of caution, however, is necessary. Studies supporting these associations are observational and do not establish definitive proof. Although researchers may posit biologically plausible connections, randomized controlled trials or definitive knowledge of disease mechanisms are necessary to confirm these associations. Nevertheless, exercising your mind and body, socializing with friends and family, and perhaps having a glass of wine, appear to stimulate brain functions. While we await disease-modifying treatments for Alzheimer’s, we can and should take precautionary steps to reduce the risk.

Barry Rovner, MD’80, is professor of psychiatry and neurology at JMC and director of clinical Alzheimer’s disease research at the Farber Institute for Neurosciences.
Great strides have been made using human embryonic stem (hES) cells. For example, current research performed at Jefferson has shown that hES cells are the only cells (in comparison to adult human bone marrow or fetal brain stem cells) that can become dopamine neurons (the cells that are lost in Parkinson’s disease) when transplanted into the brain. Other studies have found that hES cells can give rise to pancreatic islet cells, which produce insulin and replace brain cells after a stroke. These findings indicate that hES cells hold great promise for supplying an abundant source of tissue for cell-replacement therapies.

However, working with these cells can be problematic. Directing their differentiation into the appropriate cell types is not easy: they can become tumorigenic in vivo and are incapable of providing an autologous source of tissue for transplantation. Recently, researchers at Jefferson collaborated with Anthony Atala, MD, at Wake Forest to determine whether human amniotic stem cells (which share many properties with hES cells) have the same potential to differentiate into dopamine neurons in vivo. If so, these cells could address many of the ethical and practical concerns that arise from using hES cells. These cells are isolated from amniotic fluid, and therefore do not involve destruction of the embryo. What’s more, they are not tumorigenic and, if banked at birth, can provide an autologous source of tissue for cell replacement. This evidence shows a fundamental need for additional investigation.

In the U.S., the lack of availability of hES cell lines and limited medical research have clearly affected progress in this field. Too few scientists choose to pursue these studies, particularly for the purposes of cell-replacement therapies. There are several reasons for this. First, the cells themselves are very difficult to handle and require daily attention, year round. Second, since September 9, 2001, there has been a government ban preventing researchers from using federal grants to study all but a few hES lines that are rapidly senescing. Therefore, although there are many far superior hES cell lines available from private sources, researchers are unable to use NIH grants to study them (or use supplies and equipment in labs that are purchased with NIH moneys).

While researchers are concerned about hES research, there are positive indications that these limitations will be lifted sometime after the 2008 presidential election. Most of the leading political candidates profess their support of embryonic stem cell research and promise to institute laws supporting its development. But whatever the outcome of the election may be, the implementation of these new laws remains uncertain.
These are complicated questions, because cancer, by definition, is a genetic disease. Cancer is not simply one disease, but more than 100 individual diseases that share some common characteristics, mainly the extreme overgrowth of cells in the body’s various organs and tissues.

Many steps are involved for a cell to become cancerous, and most cancers develop randomly. In some cases, however, specific experiences — exposure to harmful substances such as cigarette smoke, for example — can lead to genetic changes in cells and eventually to cancer.

Generally, researchers classify two major types of “cancer genes.” One type is an oncogene, which actively causes the out-of-control cell growth that is the hallmark of all cancers. The other type is a tumor-suppressor gene. These genes normally act as guardians against the development of cancer, blocking tumor formation. When they are altered — “mutated” — in some way, inhibited, or even missing, cancer may occur.

While hereditary cancers represent a small percentage of cancers, scientists have identified several types in the past decade that involve specific genes that are directly attributed to the disease. The most famous of these occur in breast and colon cancer. In the early and mid-1990s, scientists identified BRCA1, and later, BRCA2, normal tumor suppressor genes that when damaged, dramatically increase the risk of developing breast cancer. These inherited cancer gene mutations usually lead to breast cancer at an early age in a high percentage of women who carry them. To a lesser degree, the mutations also raise the risk of developing ovarian cancer.

In colon cancer, inherited mutations in the APC gene result in a type of colon cancer syndrome called Familial Adenomatous Polyposis, or FAP, which have an extremely high likelihood to develop colon polyps and cancer. Another similar syndrome is Hereditary Non-polyposis Colorectal Cancer (HNPCC). The colorectal cancers and polyps occur at an unusually young age, and tumors and cancers may also occur in other organs.

The second issue — escaping one’s genetic heritage — leads to more difficult questions and decisions. Both types of inherited cancers are suspected when they occur in multiple generations of a family. It helps if the hereditary cancer is known, and individuals can be screened. Finding both breast and colon cancers early on are key to successful prevention and treatment. In some cases, patients opt for prophylactic surgery.

Because so many biological pathways — and genes—are involved in the development and spread of cancer, researchers are attacking a huge array of targets in hopes of understanding how to thwart the disease. Recently, a team at the Kimmel Cancer Center at Jefferson identified a gene and protein that may play an important role in the spread of about one quarter of all breast cancers. The protein, Akt1, could be a potential target for new drugs to stop or slow the growth and progression of the disease.

Richard Pestell, MD, PhD, is the director of the Kimmel Cancer Center at Jefferson. Pestell has authored more than 440 published works, 270 original publications and book chapters, and more than 170 published abstracts. His major contributions have been in the areas of breast and prostate cancer and targeted cancer therapies.
Who should be tested for HIV infection?

Joseph A. DeSimone Jr., MD, PGAIDX'97

For many years, the Centers for Disease Control and Prevention (CDC) has recommended routine HIV testing among high-risk groups (e.g., intravenous drug users) and in high-prevalence settings. This testing process has traditionally required pre-test counseling and written informed consent.

However, it is estimated that approximately one quarter of the one million HIV-infected Americans are unaware that they are infected. It is possible that these undiagnosed individuals are responsible for many of the 40,000 new HIV infections that occur each year in this country. Furthermore, almost half of these new cases are diagnosed in individuals who have already progressed to advanced stages of the illness (i.e., AIDS). There are clearly inadequacies with the current HIV screening methods.

As a result, the CDC has recently issued revised recommendations for HIV testing in adults, adolescents, and pregnant women. HIV screening is now recommended for all adults and adolescents ages 13 – 64 in all healthcare settings. In addition, the revised recommendations suggest HIV testing for people at high risk at least once a year. They also suggest that screening should be incorporated into the general consent for medical care; separate written consent is not recommended. Furthermore, prevention counseling should not be required as part of HIV screening.

These revised recommendations for routine, voluntary testing in all adolescents and adults stem from the above-noted problems with our current testing system. Since the advent of highly active antiretroviral therapy (HAART), people living with HIV have significantly longer life expectancies. In one recent survival study, the estimated median survival in the HAART era was more than 35 years. Earlier identification of such persons will allow them to benefit from HAART and will also reduce the number of persons who learn their status concomitant with an AIDS diagnosis.

Identification of persons with HIV may also reduce the incidence of new infections in the U.S. Most persons, once they learn they have HIV infection, will significantly alter their high-risk behaviors. It is estimated that new sexually transmitted HIV infections can be reduced by more than one third per year if all HIV-infected persons knew of their infection and modified their behavior.

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In additional to screening a broader group of persons, the new recommendations also simplify the testing process. The guidelines state that separate written consent to test the patient for HIV infection is not recommended. This is still a voluntary test. The patient should be informed that HIV testing will occur as part of their general medical care, but the patient has the right to “opt out” or decline testing. This opt-out testing method results in higher numbers of patients screened, as compared with the traditional opt-in method. Although the CDC strongly endorses prevention counseling when testing for HIV infection, the guidelines realize that such counseling can hinder the process, and recommends that this counseling not be required.

These recommendations are intended for all healthcare providers in the public and private sectors. These settings include hospital emergency rooms, urgent care clinics, inpatient services, public health and community clinics, correctional healthcare facilities, prenatal clinics, and other primary care environments.

Lastly, it should be noted that these testing recommendations are still only recommendations from the CDC. Government legislature to mandate that these guidelines be followed has yet to occur. Hopefully, the above guidelines will soon become more than just CDC recommendations.
Obesity is epidemic in the U.S. and disproportionately affects low-income and minority groups. For example, in Philadelphia, over a quarter of all adults are obese (with African Americans having a higher risk than Latinos and Whites). Among these individuals, many suffer from diabetes, heart problems, elevated blood pressure, and cholesterol. Just over half of obese individuals in inner-city Philadelphia neighborhoods get the recommended exercise, and the majority report that they do not eat the recommended five servings of fruits and vegetables daily. Personal, cultural, environmental, and economic factors make it difficult, particularly for low-income African-Americans and Latinos, to engage in healthy lifestyles. Focus groups with individuals from the neighborhoods, conducted in 2005, reveal barriers to engaging in healthy lifestyles to include a lack of access to low-cost fresh fruits and vegetables; the expense of weight loss/physical activity programs; and the stress of having to exercise in “life already too stressful” situations.

To support more healthy lifestyles in these communities, physical activity must be built seamlessly into routine activities, and skill-building activities such as meal planning, healthy eating on a limited budget, choosing healthy snacks, and healthy cooking for families must be taught.

Well-controlled clinical trials have demonstrated that lifestyle modifications can decrease blood pressure, prevent or forestall development of type 2 diabetes, and reduce other risk factors for cardiovascular disease. The health benefits of weight loss and increased physical activity are well established. Modest weight loss of 5–10 percent is associated with significant improvement in blood pressure, lipoprotein profile, glucose tolerance, and insulin sensitivity. Physical activity has similar benefits on cardiovascular risk factors.

Healthcare providers can and should be primary motivators and monitors of behavior change in individuals and families. However, obese individuals receive advice to lose weight only half of the time. Only 34 percent of adults seeing a physician in the prior year reported being counseled about physical activity at their last physician visit. Disparities exist in professional advice to lose weight — the lower the income and educational attainment, the less likely the provider will offer advice to lose weight. African Americans, compared with Whites, have significantly lower odds of receiving weight advice counseling. The finding that providers under-diagnose obesity by relying on appearance and not body mass index (BMI) highlights the importance of teaching and modeling the use of BMI to diagnose overweight and obesity. Healthcare providers fail to address obesity for a variety of reasons including “clinical inertia” or the failure to initiate or intensify therapy when indicated, lack of time, perceived non-compliance of participants, and a lack of training in counseling and motivating participants to change their behavior. Clinical guidelines exist for obesity assessment and management, but are not routinely used.

Obesity and its associated co-morbidities are chronic disorders. As with other chronic disorders, effective clinical management of obesity requires that clinical practices be organized to facilitate provider compliance with clinical care guidelines, and to assist participants in developing and implementing strategies for self management and behavior change.

What should primary care physicians be doing to combat the obesity epidemic?

James Plumb MD’74, MPH

James Plumb, MD’74, MPH, associate professor of family and community medicine, currently is the director of Thomas Jefferson University Hospital’s Office to Advance Population Health. Plumb and his team are involved in care, service, educational, and research initiatives in Philadelphia neighborhoods focusing on obesity, hypertension, and stroke prevention and management within vulnerable populations.
The most common question I am asked prior to cardiac catheterization is, “Are you going to use one of those stents I’ve heard about on the news recently?” The extensive media coverage of late-stent thrombosis for drug-eluting stents (DES) concerns patients.

Balloon angioplasty was introduced in the 1970s. Although effective at opening stenotic (clogged) arteries, it was hindered by mean angiographic restenosis rates in the 40 – 50 percent range: worse for high-risk lesions such as long lesions or small caliber vessels especially in diabetic patients; better for low-risk lesions.

Bare-metal stents (BMS) were released in 1993 and significantly reduced the angiographic restenosis rate for coronary interventions to 20 – 30 percent. BMS also resulted in better short-term results: less residual stenosis, fewer dissections, and lower rates of in-hospital infarctions and other unplanned surgeries. (Much of the sentinel research for BMS was done at Jefferson Medical College.)

In 2003, drug-eluting stents were released after trials revealed improved restenosis rates compared with BMS; angiographic rates of 7 – 10 percent with clinical restenosis rates of approximately five percent. Today, two DES are FDA approved. Each device consists of a bare-metal stent, a polymer, and an antimetabolite drug, which is almost entirely resorbed within 30 days. The drug prevents neo-intimal hyperplasia, which is the mechanism for restenosis.

Subacute thrombosis (SAT) is a clot forming on the stent 24 hours or more after the patient leaves the catheterization lab. The primary mechanisms for SATs are strut malapposition, edge dissections, and inadequate/ineffective antiplatelet therapy. The rate of SAT in BMS is approximately 0.7 percent, and the vast majority of these events occur within 30 days after implant. After this period of time, the stents are felt to have endothelialized, which protects them against thrombus formation.

What has been newsworthy is the fact that DES have demonstrated late (later than 30 days) and very late (later than one year) subacute thromboses. Indeed, evidence shows DES endothelialize later than BMS, and this may be the mechanism for such late closures. The overall rate of SAT is slightly higher than for BMS although careful review of each of the published trials indicates the rate of death or myocardial infarction does not appear to be higher compared to BMS. This slight increased risk of a late SAT distinguishes it from BMS.

Most (but not all) of these events occur within the setting of discontinuation of antiplatelet therapy (oftentimes for a surgical procedure). This has led to the recommendation that dual antiplatelet (aspirin and clopidogrel) therapy be continued for one year post-implant (unless the patient is at high risk for bleeding). Until this data was available, most patients received three – six months of the dual drugs, then aspirin alone.

A special FDA panel was convened in January 2007 to review all of the available data regarding the safety of DES. They concluded that drug-eluting stents are safe when used on-label, and antiplatelet therapy is taken appropriately.

Drug-eluting stents are very useful when used properly. They are most beneficial in lesions at high risk of restenosis. I use BMS for lower-risk lesions or patients at increased risk for bleeding. Other therapeutic options (such as bypass surgery or medical therapy) should be considered if the patient has a high-risk lesion and is not a good candidate for a DES.

Joseph G. Lewis, MD’86, FACC, FSCAI specializes in cardiac and peripheral catheterizations/interventions with Chester County Cardiology Associates in West Chester, PA. He is also the medical director of Peripheral Vascular Interventions at the Chester County Hospital.
Last year microscopic anatomy students leapt into the 21st century when Jefferson replaced traditional microscopy with virtual microscopy in the microscopic anatomy lab.

The virtual slides used in the class are not simple digital images. Instead, microscope slides have been scanned at high resolution. The students can study the images like a slide: they are able to move the specimen around the computer in real time as on a microscope stage. Students can change magnification from 1x to 1000x. In some of the specimens, the mouse scroll function can be used to allow the students to focus through the specimen as they would with the fine focus on the microscope. David E. Birk, PhD, professor of pathology, anatomy, and cell biology, explains, "They are studying the material like they would using a microscope. It is useful to remember that microscope-intensive areas like pathology and hematology gave up microscopes probably a decade ago for teaching, relying instead on static images."

The biggest benefit to this new use of technology is that every student can look at the same image at the same time. This addresses the most troubling problem found in the microscopic anatomy lab: under the old system, teachers could not be sure what students were seeing when they looked into their microscopes. Now instructors can monitor what all students see. Furthermore, control of all the computers can be shifted to the lecturer so that he or she can make a point for the entire classroom.

Even better for students, they can review the virtual slides at any time or any place—they are no longer weighted down by their microscopes. In addition to better access to the images, students can print the images they are studying, mark them up, and enhance them.

The new approach also saves students some money. Microscope rental runs $130.50 per student. This may seem like a small amount, but it results in a total savings for $27,000 – $30,000 per class.
The biggest hurdle the team faced was changing faculty perceptions and attitudes. Many had concerns about the new program, reports Edward W. Tawyea, director of Jefferson’s Academic and Instructional Support and Resources (AISR). Faculty worried that students would not have the opportunity to learn to use a microscope. “We made microscopes and glass slides available in each lab as well as in Scott Library Reading Commons. The Scott microscopes were checked out a total of six times, all in the first week,” said Birk. “Most of the skepticism comes from people who have never used the system and equate it with a digital image bank. The complaints have been mostly the gut response that we can’t give up the microscope, and that students will need to know how to use a microscope. Most everyone who has evaluated the system has become supportive.” “Faculty assistants are no longer skeptical,” agrees Tawyea.

In addition to the faculty’s uncertainty, the AISR, which provides leadership for new technology and new educational solutions, faced the challenge of configuring a room that seats over 130 students: how could they put 128 personal computers in the space? “Logistically and financially, it would cost a lot,” Tawyea said. Using a special card, the computers can run five monitors from one PC, and each monitor can run independently of the others. Suddenly, instead of needing 128 new computers for the classes, only seven were needed. The collaborative environment is designed in such a way that two students share a monitor. The faculty members have noticed that students are discussing what they see more than they did in the past. “The technology isn’t that innovative; it’s how we’re using it that’s new,” explains Tawyea.

One of AISR’s concerns about reconfiguring the laboratory space was how they could install computers in a room that was designed to be wet. AISR acquired special sealed keyboards, “designed for tough environments,” explains Martha Ankeny, director of Learning Resources in AISR. The rooms were completely rewired for data connections, and a network was installed to run the technology. The laboratories offer computers to the students, but “you can still dissect brains there,” reports Ankeny. “It’s a much richer learning environment.”

AISR offers other novel ideas to the teaching of the medical arts. They are currently converting video of gross anatomy to digital media so students can watch dissections as streaming video. Students have access to the Visible Human Dissector Program, which provides 3-D visualizations and cross sections based on the Visible Human Project. With this product, students can compare the cellular and gross levels. The program has not replaced regular dissection classes, which are “more alive, so to speak, more real,” according to Tawyea. Students are examining these resources on their own, and with wireless connectivity, they can access them all over campus.

Of the nearly 96 percent of students surveyed after the first year in virtual microscopy, Birk reports, “The vast majority believe that virtual slide box is a good learning tool. Only eight percent believe that microscopes are important for learning microscopic anatomy.”

And there is no more time lost fiddling with microscopes. Birk asserts, “These students will be better doctors because they will focus on learning the process of evaluation, not the technical detail of using a microscope. They learn how to evaluate the slides.”

“Students are discussing what they see more than they did in the past.”
Clarence Miller reports from Sewickley, PA, that he has wet macular degeneration, but he is still able to read and drive as a result of monthly intravitreal injections of lucentis. His activities include traveling, reading, walking, and directing the activities of one aging racehorse.

Raymond Dandrea is fully retired and spends seven months of the year in Guilford, FL, and live in PA. He dedicates himself to mastering the game of golf.

Leonard S. Girsh is chairman and CEO of Immunophath Profile Inc. His company was recently awarded a development composition comprising a synthetic stem cell functionality patent by the U.S. Patent and Trademark Office, developed under the trademark CellBiochrome Stem Cell Repair KitTM, Genomic Repair KitTM. He lives in Naples, FL.

Jay A. Nadel recently received the René Descartes Medal from the University of Paris for outstanding contributions to the university. Nadel has spent many years mentoring and collaborating with researchers in Paris.

Max Koppel, who lives in Huntingdon Valley, PA, was recently tickled to discover that his grandson, Zachary Birenbaum, plays on the same line of the boy’s varsity lacrosse team at Harriton High School as Will Carabasi, grandson of Ralph Carabasi ’47.

Phillip J. Marone of Haddonfield, NJ, received his MPH from Jefferson in June.

Marvin A. Sackner, currently the chairman of the board of directors on Non-Invasive Monitoring Systems, Inc., was awarded an honorary doctor degree by the faculty of medicine, University of Zurich on April 28, 2007. His received the award in “recognition of his great achievements in the field of modern experimental and clinical pulmonary medicine and his intense scientific collaborations with the Clinic of Pneumology of the University of Zurich.” Sackner and his wife, Ruth, are founders of the Sackner Archive of Concrete and Visual Poetry. They were named by Art & Antiques as one of the 100 collectors changing the art world. The couple resides in Miami, FL.

James McCallum has been retired since 1995 and reports from Clayton, WA, he is enjoying “golfing and doing an ample amount of chores.” His father, Arthur, was MD ’22.

W. Daniel Stevenson has retired after 31 years as a general surgeon. He reports that he is now resting and enjoying his four grandchildren at his home in Dallas, TX.

John D. Frost has a private arthroscopic knee surgery practice in Anchorage, AK, which allows him to travel worldwide.

Joseph F. Kestner Jr. of Wilmington, DE, is happy to report that son Christopher graduated from Jefferson in 2006 and currently is a resident in orthopaedic surgery at Temple University Hospital.

Harold Yokum retired from full-time orthopaedic/hand surgery. He will continue part time in the University of Oklahoma orthopaedic department with clinical training, clinics, and surgery. “Life holds more walks with our Maltese, working in the yard, bird watching, and scouting.” Yokum was recently selected to receive scouting’s highest national award for distinguished service: the Silver Buffalo.

Marc Goldberg received his law degree with honors from Rutgers University-Camden, NJ, in January 2007. Goldberg currently practices anesthesiology at Jefferson Hospital for Neuroscience and other Delaware Valley locations. He hopes to some day work in the legal field in property law.

Glenn Hyatt is an internist affiliated with Abington Memorial Hospital. He practices in Maple Glen, PA. His son Jordan is a second-year law student at Villanova; son Adam is a second-year medical student at Jefferson; son Dan is a sophomore at Penn State University.

John P. Welch of Lebanon, PA, is proud to announce his daughter, Elizabeth, is a 2007 graduate of JMC and will begin her residency in family medicine at the Cleveland Clinic. His son, John, is MD ’99.

J. Christopher Daniel is the community officer of the Naval Medical Research Center in Silver Springs, MD, and the director of Navy medicine research and development. Daniel oversees 10 research labs around the world.

John Spurlock has returned to private practice in urogynecology and pelvic reconstruction in Bethlehem, PA, after spending 10 years as an employee of St. Luke’s Hospital. Spurlock enjoys private practice because he has more time for scuba diving and flying his airplane to diving sites. He and wife, Lisa, recently celebrated their 25th wedding anniversary.

Brenda Horwitz is an associate professor of medicine in the section of gastroenterology at Temple University Hospital. She is the gastroenterology fellowship director. Horwitz, who lives in Plymouth Meeting, PA, enjoys spending time with her two daughters, Alexa (10) and Olivia (9), and her husband Brett (PGOR’90). Her hobbies include squash, physical fitness, gardening, and spending time at her home in Naples, FL, with family and friends.

Theodore (Ted) A. Nukes is the founder and president of Heartland Neurology, a single specialty neurology practice based in Indianapolis, IN, with 12 offices scattered about the state. He has recently returned from vacation to St. Thomas and St. John, USVI, where he enjoyed diving and sailing.

Daniel Castro is assistant clinical professor of family and community medicine at the College of Medicine, University of Arizona. He is the medical director and founder of the Pima County Refugee Clinic housed within the family and community medicine clinic. He and his wife, Rachael Pendleton, BSN ’93, live in Tucson with their four children: Lance (6), Nikos (6), Lily (2), Jordan (2).

Jeffrey Miller lives in Hershey, PA, with his five children: John (11), Matt (9), Grace (8), Maggie (6), and Will (5). He works in the department of dermatology at Penn State College of Medicine. He serves as vice chairman of education and clinical affairs and residency program director. He’s “still running, though a lot less!”

C. Robert Bernardino recently left the staff of Emory University to join Yale University School of Medicine in New Haven, CT, as an associate professor of ophthalmology and director of the oculoplastics and orbital surgery section.

Frank Campbell is an emergency medicine physician at Virtua Memorial Hospital in Burlington County. NJ. He is working as the Medical Director of Operations at Virtua West Jersey Hospital Voorhees, while continuing his clinical work at Virtua Memorial. He recently completed his MBA at the Fox School of Business. He lives in Haddonfield, NJ, with his wife, Beth, and three children, Reed, Devon, and Ashley.

Aqana Pandya Shah and husband, Chirag, welcomed their son, Rohan, on January 16, 2007. The family resides in West Windsor, NJ.

Gautam Mishra works in a private practice in ophthalmology. He lives in...
Harrisburg, PA. Daughter Anjali was born on June 15, 2006.

'00
Richard T. George completed his fellowship in cardiovascular disease at Johns Hopkins University with additional training in cardiac imaging. He is joining the Hopkins faculty as an assistant professor in the department of medicine. George recently received the Melvin Judkins Young Investigator Award from the American Heart Association. He and his wife, Tasia, have two children, Ellie and Brady.

'02
David Frankel completed his residency in family medicine at Duke University and is currently a fellow in primary care sports medicine at UCLA. He resides in Venice, CA.

Kerri Ann Simo completed her general surgery residency at Case Western Reserve University in Cleveland, OH. She will begin an abdominal transplant fellowship at UNC, Chapel Hill in July 2007.

Amy T. (Zalcman) Waldman has been awarded the 2007 National Multiple Sclerosis Society-AAN Foundation Clinician Scientist Development Award by the American Academy of Neurology Foundation for her work in developing methods to determine the visual and neurological outcomes of children with multiple sclerosis. The award is designed to encourage MS clinical research with the goal of providing better treatment, prevention, or cure for the disorder. Waldman is currently a third-year resident in child neurology at the Children’s Hospital of Philadelphia and the University of Pennsylvania School of Medicine.

PGIMX ’01
Ryan Madanick completed his fellowship at Miami and stayed on the faculty there for two and a half years. He has recently moved to Chapel Hill to join the faculty at UNC-Chapel Hill. He works in the Center for Esophageal Disease and Swallowing.

Faculty Notes
Emanuel Rubin, distinguished professor of pathology, anatomy, and cell biology and chairman emeritus of the department received the Distinguished Service Award from the Association of Pathology Chairs; the Gold Medal from the International Academy of Pathology; and the Gold Cane Award from the American Society of Investigative Pathology. He has also been funded for two new NIH grants in the field of alcohol research.

It is the policy of the Alumni Bulletin to announce neither pregnancies nor engagements, only births and weddings.

Alumni Spotlight

John Gartland, MD’44S

At the age of 88, John Gartland, MD’44S, has stamina to rival that of a med student a quarter of his age. Still active as a medical editor at Jefferson, Gartland authored 135 medical articles and four orthopaedic textbooks. He recently published his sixth book, Better Physician Writing and Speaking Skills. He commutes to Jefferson every day, plays tennis weekly with friends, and does most of his own home maintenance. When asked how he does it, he humbly says, “I always put my heart and soul into things.”

Gartland first came to Jefferson as a patient. Born with bilateral club feet, he endured 12 operations to correct the problem. During this time, he attended school but remained bedridden outside of the classroom.

Years later, Gartland returned to Jefferson, this time as a medical student. Up to this point in his life, he hadn’t even known that Jefferson had a medical college. “Even though I had all my surgeries at Jefferson Hospital, I never knew there was a medical school,” laughs Gartland. “I missed two years of school due to my surgeries so I was late applying to medical schools. I found out about Jefferson’s program and was immediately accepted.” His interest in orthopaedics grew out of his childhood surgical experiences and the influence of a third-year orthopaedic professor.

During his second year of medical school, the United States entered World War II. To ensure a sufficient number of doctors for military purposes, the Army Specialized Training Program was instituted by the U.S. government. Gartland and his classmates were told that their education would be accelerated from a 48-month program to 33 months. The students were given the option of army or navy medical student programs. Gartland chose the Army Medical Corps.

While the army was ready for doctors, the doctors were hardly ready for the army. Gartland recalls some of his funniest moments when he and his classmates were going through military training. “Unfortunately, we were trained like it was WWI,” explains Gartland. “They shot at us to make us go under the barbed wire faster and put us in rooms and turned on the gas to make sure we were able to put our masks on quick enough. It was quite an experience. The neighborhood residents would laugh at us as we did our drills. We were tripping all over each other.”

After the war, Gartland returned to Jefferson to complete his residency in general surgery then went to New York Orthopaedic Hospital at Columbia-Presbyterian Medical Center for his orthopaedics residency. For several years he worked at various hospitals including Methodist Hospital and Lankenau Hospital in Philadelphia and became board certified in orthopaedic surgery. But a call from Dean William Kellow brought him back to Jefferson once again.

“Dean Kellow asked me to come back to Jefferson as chairman of orthopaedic surgery. My wife thought I was crazy. The salary was a quarter of what I was making at Lankenau, but the lure to teach was what brought me back.” Gartland spent the next several years building the orthopaedics department and its residency program.

Gartland has been a fixture at Jefferson ever since. Although he retired several years ago from practice and teaching, he remains at Jefferson devoting his time to counseling fellow physicians and students and writing books specifically geared to instructing healthcare professionals on how to produce materials for the medical world. He is also a featured author for the Alumni Bulletin, regularly contributing historical articles.

“John brings seven decades of working knowledge of Jefferson to every meeting he attends,” says William V. Harrer, MD’62. “His factual insights are well researched, and his opinions are firm and well based. He truly defines what Jefferson is all about.”

When asked what has kept him here all these years, he simply states, “There’s a small town mentality around here that you don’t see at other medical schools and besides, my wife won’t let me move.” He adds, “I have always believed Jefferson has a lot of potential, and I try to do my part to make things better.”
In Memoriam

Gabriel E. DeCicco ’36 died on April 23, 2007. DeCicco had a family practice from 1937 until his retirement in 1979. From 1979 through 1984, he was a physician for the Advisory Utilization Review program for the Youngstown Hospital Association and later served as president of staff. A World War II Army veteran, he was awarded four Bronze Stars, the Asiatic-Pacific Service Medal, and the Philippines awarded four Bronze Stars. He was a member of the Alpha Omega Alpha Honorary Medical Society. He served in WWII as a physician with General George Patton. He practiced orthopedic surgery in Washington, DC, where he was held in high regard both locally and nationally. He is survived by his wife, Marian, two sons and a daughter. His son, Stuart, is MD’81.

Martin Green ’38 died February 14, 2005. He practiced pediatrics in Atlantic City, NJ, and was on staff at the Atlantic City Hospital. He is survived by a son and a daughter.

Edward T. Horn ’40 died February 28, 2007. He practiced emergency room medicine in St. Luke’s Hospital, Bethlehem, PA, and at Pocono Hospital, East Stroudsburg, PA. He is survived by his wife, Eleanor, three daughters, and three sons.

Edmund T. Hackman ’42 died April 25, 2007. Hackman served as a health officer for the U.S. Coast Guard during World War II. He maintained a family practice for 41 years in Rhode Island before retiring in 1987. He served as president of the Rhode Island Medical Society and as a state delegate at AAMA conventions. Hackman was also a president of the Kent County Medical Society and a health officer for the city of Warwick. He is survived by his wife, Mary, four sons, and three daughters.

John H. Bland ’44J died March 15, 2007. He was a professor of medicine and urology at the University of Vermont. A published author and lecturer, he was a frequent NIH research grantee, a Fulbright Visiting Senior Scholar, and was named master of rheumatology by the American College of Rheumatology. He is survived by his wife, two daughters, and a son.

James G. Foley ’44S died February 14, 2007. He was a family physician in Millington, NJ. He is survived by his wife, Helen, four daughters, and three sons.

John M. Vesey ’45 died March 21, 2007. He practiced in Rhode Island for 30 years where he served as chief of staff and director of radiology at Kent County Memorial Hospital. He is survived by his wife, Annette, four daughters, and a son.

Bruce Wimer ’46 died April 1, 2006. At graduation from Jefferson he became a member of the Alpha Omega Alpha Honorary Medical Society. Board certified in internal medicine, he practiced at the Lovelace Clinic, Albuquerque, NM. A fellow of the American College of Physicians, he retired from medical practice in 1991 due to illness. He is survived by his wife, Polly, two daughters, and a son.

John M. Koval ’47 died February 26, 2007. He practiced cardiology in Miami, FL, at South Miami and Doctors’ Hospital, Miami, FL. He is survived by his wife, Maureen, two sons, and a daughter.

Arthur R. Vaughn Jr. ’47 died January 17, 2007. He served as chief of ophthalmology at Jeaneas Hospital, Philadelphia, PA. An accomplished figure skater, he won the Men’s Singles National Figure Skating Championship in 1943. He is survived by his wife, Charlotte, two sons, and a daughter.

Neilson Schimmel ’48J died January 18, 2007. He was president of external affairs at both Warner-Lambert Research Institute and Schering-Plough. He is survived by his wife, Patricia, a daughter, and a son.

Norman J. Fisher ’49J died March 27, 2007. He practiced in Hattboro, PA, and served as Hattboro’s health commissioner. He is survived by his wife, Doris, and two daughters.

John R. Healy ’49J died February 11, 2007. He practiced obstetrics-gynecology in Madison, WI. After an early retirement, he worked for 14 years in the Student Health Service, University of Wisconsin, Madison, WI. He is survived by his wife, Patricia, two sons, and a daughter.

Henry M. Perry ’49 died May 15, 2007. Perry joined the Gilfillan Clinic in Bloomfield, IA, in 1963 and practiced internal medicine and gastroenterology at the Davis County Hospital and St. Joseph Hospital. He retired from his practice in 1990. He is survived by his wife, one son, and three daughters.

Darrell C. Stoddard ’50 died March 25, 2007. He practiced family medicine in Idaho Falls, ID. He is survived by his wife, Jackie, and six sons. Son Bradley is MD’87.

Howard C. Mofenson ’51 died April 7, 2007. He was the founder and director of the Long Island Regional Poison Control Center. He was published widely in the field of poison control for child safety. He is survived by his wife, Lois, two daughters, and a son.

Russell W. Schaedler ’53 died on May 8, 2007. Schaedler was a longtime chairman of the department of microbiology at Jefferson and worked with the famous scientist and Pulitzer Prize winning author, Rene Dubos. Schaedler was known for being the first to “normalize” germ-free mice by colonizing them with members of the normal autochthonous microflora of the laboratory mice.

William C. Sugg ’53J died January 18, 2007. He practiced internal medicine at the Forsyth Medical Center, Winston Salem, NC.

Frederick S. Wilson ’53J died January 13, 2007. He worked for Wyeth Laboratories in clinical research and drug development and had a practice in Carlisle, PA. He is survived by his wife, Ruth, and three daughters.

Phillip M. Hunsicker ’54J died February 27, 2007. He was a general practitioner in Southhampton, PA. He is survived by two sons.

Mark H. Hassel ’85J died January 25, 2007. He practiced in Lancaster, PA. He was a member of the teaching staff of the Dermatology Clinic at Lancaster General Hospital and a fellow of the American Academy of Dermatology. He is survived by his wife, Jennifer, two daughters, and a son.

Faculty

Harry L. Smith Jr., PhD, professor emeritus of microbiology and immunology, Jefferson Medical College, died December 6, 2006. Well known and highly regarded at Jefferson for his knowledge, wit, and infectious good humor, he was a very popular teacher at Jefferson and a friend to all. He is survived by his wife, Frances, three sons, and two daughters. Son Kenneth is MD’79 and son David is MD’84.

P GA

Laurence B. Hall, PGA, Psychiatry 1950, died March 1, 2007. He was a clinical professor of psychiatry, University of Colorado Health Sciences. He is survived by his wife, Janet, a daughter, and a son.
The End of an Era:
A Tribute to John Y. Templeton III, MD'41

John Y. Templeton III, MD, passed away on March 27, 2007. An icon in the department of surgery at Jefferson, Dr. Templeton, known as “Temp,” was a giant among giants. There was no other like him. There may never be another quite like him.

Dr. Templeton was born in Virginia, the oldest of four children. His father, John Y. Templeton II, was also a physician, and his brother Thomas is a physician and Jefferson graduate. Upon graduation from Davidson College in 1937 with honors, he attended Jefferson Medical College and obtained his medical degree in 1941. He completed his surgical training at Jefferson then served in the military medical corps during World War II. He returned to Jefferson in 1950 to complete his training and later joined the surgical department under the tutelage of Dr. John Gibbon. Working with Dr. Gibbon, Dr. Templeton was instrumental in the development, implementation, and expanded use of the heart-lung machine at Jefferson.

Dr. Templeton was an exceptionally bright and talented individual. His distinguished career encompassed medical research, surgical innovation, training of young surgeons, and leadership positions in medical societies and organizations. He ascended the academic ranks, achieving a full professorship at Jefferson and then at the University of Pennsylvania while serving as the chairman of the department of surgery at Pennsylvania Hospital. He returned to Jefferson upon Dr. Gibbon’s retirement to become the fourth Samuel D. Gross Professor and Chairman of the Department of Surgery in 1967. He remained at Jefferson until his retirement from active practice in 1987.

Despite Dr. Templeton’s many contributions to literature, science, organizational medicine, and patient care, his greatest contributions were teaching and mentoring surgeons in training. An inspirational surgeon, with exceptional technical skills, he was creative, ingenious, and courageous. He was a beacon to young trainees of what a surgeon should be.

“Temp” will be remembered for his many attributes, surgical proficiency, exceptional technical skills, brilliance, ingenuity, dignity, respect, and work ethic. While working with Dr. Templeton in his 67th year, I was amazed how he could perform like an intern. He never fatigued, mentally nor physically. “The distinction of a true surgeon is one who takes on the most challenging of patients and achieves good results,” he once said.

Even in a crisis, his humor was present, and of the endless stories there are about Temp, most of them relate to his humor and his well-timed one-liners accented by his distinctive North Carolina drawl. He taught us that the operating room was a place to be enjoyed, and if we were enjoying ourselves, we would perform well.

The legacy of John Y. Templeton III, his remarkable talents and skills endure every day in universities, hospitals, and communities across the country carried out by those who trained under him. I had the privilege of being with Temp in his waning hours, and on behalf of all of those he trained, I thanked him for making us such fine surgeons. It is a privilege to offer this writing to the Jefferson Alumni Bulletin in honor of “Temp”, John Y. Templeton III.

– Robert S. Boova, MD’77
Hale, Benjamin P.  
Geisinger Medical Center, PA

Hirokawa, Dawn E.  
Christiana Care, DE

Hung, Joseph C.  
Lankenau Hospital, PA

Kaplan, Judith L.  
Beth Israel Medical Center, NY

Kumar, Rohini J.  
Albert Einstein Medical Center, PA

Lehman, Amanda Y.  
Lankenau Hospital, PA

Mallon, Mary G.  
Thomas Jefferson University Hospital, PA

Menashe, Sarah J.  
Lankenau Hospital, PA

Millett, Christian R.  
UMDNJ-R.W. Johnson Medical Center-Camden, NJ

Moore, Sarah J.  
New York University School of Medicine, NY

Ng, Andrew T.  
Lankenau Hospital, PA

Parish, Daniel H.  
Pennsylvania Hospital, PA

Pramick, Michelle R.  
Abington Memorial Hospital, PA

Ruzbarsky, Allison L.  
Reading Hospital and Medical Center, PA

Shah, Shaan H.  
Thomas Jefferson University Hospital, PA

Simpao, Allan F.  
Lankenau Hospital, PA

Swavely, Karen A.  
Hershey Medical Center/ Pennysylvania State University, PA

Tong, Melissa G.  
Thomas Jefferson University Hospital, PA

Neurology
Boland, Torrey A.  
Thomas Jefferson University Hospital

Gangal, Kaanchan S.  
University of Virginia, VA

Neurological Surgery
Chitale, Rohan V.  
Thomas Jefferson University Hospital, PA

Panov, Fedor E.  
Mt. Sinai School of Medicine, NY

Vadern, Sumeet  
Cleveland Clinic Foundation, OH

Obstetrics/Gynecology
Cannon, Jamie M.  
Thomas Jefferson University Hospital, PA

Krapf, Jill M.  
George Washington University, DC

Ophthalmology
Dugar, Jyoti R.  
Drexel University College of Medicine, PA

Ergas, Heath B.  
West Virginia University, WV

Giordano, Candice R.  
Souz Hospital, MD

Hale, Benjamin P.  
Geisinger Medical Center, PA

Lehman, Amanda Y.  
North Shore-Long Island Jewish Health System, NY

Patel, Ravi D.  
University of Pittsburgh Hospital, PA

Richman, Jesse  
Brown University Hospital, RI

Rodgers, Samantha B.  
NCC Walter Reed Army Medical Center, DC

Schrack, Katie E.  
Temple University Hospital, PA

Shienbaum, Gary  
Wills Eye Hospital, PA

Smith, Jordana M.  
Pennsylvania State University, PA

Wang, Eileen  
Wills Eye Hospital, PA

Weber, Mariissa L.  
Walter Reed Army Medical Center, DC

Orthopaedic Research
Gilotra, Mohit N.  
University of Maryland Medical Center, MD

Orthopaedic Surgery
Anderson, David T.  
Thomas Jefferson University Hospital, PA

Chaudhry, Sonia  
NYU Medical Center/Hospital Joint Diseases, NY

Grossman, Seth A.  
Einstein/Montefiore Medical Center, NY

Jorgensen, Anton Y.  
William Beaumont Army Medical Center, TX

Kurd, Mark F.  
Thomas Jefferson University Hospital, PA

Maloney, Patrick J.  
Geisinger Health System, PA

Please send us an update for the Bulletin’s Class Notes section. Photos are especially welcome. Please identify all individuals in the photo to ensure accuracy.

Mail to: Editor, JMC Alumni Bulletin, Thomas Jefferson University 925 Chestnut Street, Suite 110, Philadelphia, PA 19107

Or update your information and upload photos to our online community: http://alumniconnections.com/olc/pub/JFDM and click on the Class Notes link.

Name
Class year
Current specialty
Preferred address
City/State/Zip
Preferred phone
Preferred e-mail address

Your news

Information/articles you would like to see in the Bulletin

The Bulletin welcomes news and photographs of individuals and reminds you that it may take several months for your class note to appear in print.
Neuman, Brian J.  
Thomas Jefferson University Hospital, PA

Norton, Robert P.  
Jackson Memorial Hospital, Fl.

Slonker, Nicholas R.  
Thomas Jefferson University Hospital, PA

Wilson, Kevin W.  
National Naval Medical Center, MD

**Otolaryngology**
Friedel, Mark E.  
UMDNJ-New Jersey Medical Center- Newark, NJ

Goldstein, Gregg H.  
Mt. Sinai Hospital and Clinics, Wi

McGeehtigan, Brian E.  
Thomas Jefferson University Hospital, PA

**Otolaryngology**
Research
Kopelovich, Jonathan  
University of Iowa Hospital and Clinics-Iowa City, IA

**Pathology**
Holdbrook, Thomas  
Thomas Jefferson University Hospital, PA

Jaworski, Mark P.  
Drexel University School of Medicine, PA

Kastenbaum, Hannah A.  
University of Pittsburgh Medical Center, PA

Newcomer, Julianne  
Vanderbilt University Medical Center, TN

Toll, Adam D.  
Thomas Jefferson University Hospital, PA

**Pediatrics**
Boghara, Zarana R.  
Emary University School of Medicine, GA

Cellini, Melissa M.  
Westchester Medical Center, NY

Del Pizzo, Jeannine A.  
University of South Florida College of Medicine-Tampa, Fl.

Dubrovsky, Leonid  
Children's National Medical Center, DC

Hesler, Jennifer J.  
Thomas Jefferson University/duPont Children's Hospital, PA

Khojasteh, Soreena  
Einstein/Montefiore Medical Center, NY

Kondrich, Janienne  
NYP Hospital-Columbia University Medical Center, NY

Kuo, Marymane M.  
Thomas Jefferson University/duPont Children's Hospital, PA

Martin, Allison M.  
University of Pittsburgh Medical Center, PA

Porro, Jesse C.  
Yale-New Haven Hospital, CT

Rao, Sonaly S.  
University of California-San Diego Medical Center, CA

Rapson, Alicia K.  
St. Christopher's Hospital, PA

Sammon, Mary R.  
Thomas Jefferson University/duPont Children's Hospital, PA

Schultz, Corinna L.  
Rhode Island Hospital/Brown University, RI

Slingsby, Brett A.  
Eastern Virginia Medical School, VA

Ziss, Bethany E.  
Marshall University School of Medicine, WV

**Pediatrics Primary**
Wellington, Abigail C.  
Mt. Sinai Hospital, NY

**Physical Medicine and Rehabilitation**
Kumar, Rohini J.  
Temple University Hospital, PA

**Psychiatry**
Beyer, John J.  
University of Maryland Medical Center, MD

Cantor, Jillian B.  
Thomas Jefferson University Hospital, PA

Marchioni, Christine S.  
Thomas Jefferson University Hospital, PA

Segal, Pavan N.  
California Pacific Medical Center, CA

Shah, Sejal B.  
Harvard Longwood Psych/Carney Hospital, MA

Smith, Shaun E.  
University of Connecticut Health Center, CT

**Radiation Oncology**
Cupino, Andrew C.  
University of Virginia, VA

Lubbe, Wilhelm J.  
Fox Chase Cancer Center, PA

**Radiology-Diagnostics**
Chazen, Joseph L.  
NYP Hospital-Weill Cornell Medical Center, NY

Daniel, Adam  
Geisinger Health System, PA

Gallagher, Dierdre  
University of Pittsburgh Medical Center, PA

Hoey, Courtney L.  
Thomas Jefferson University Hospital, PA

Kaplan, Judith L.  
Mt. Sinai Hospital, NY

Mallon, Mary G.  
Bryn Mawr Hospital, PA

Masuda, Emi  
Henry Ford Health Science Center, MI

Moormjan, Lauren N.  
St. Luke's-Roosevelt Hospital, NY

Patel, Sharmishtha  
Temple University Hospital, PA

Ruzzbarsky, Allison L.  
George Washington University, DC

Shah, Shaan H.  
Brigham & Women's Hospital, MA

Spina, Michael J.  
Christiana Care, DE

Wiley, Mark R.  
UMDNJ-R.W. Johnson Medical Center-Camden, NJ

**Surgery**
Aftuso, John  
UMDNJ-R.W. Johnson-Piscataway, NJ

Amann, Christopher J.  
Naval Medical Center-San Diego, CA

Long, William D.  
Yale-New Haven Hospital, CT

Marks, Joshua A.  
Thomas Jefferson University Hospital, PA

Pardus, Jessica L.  
Geisinger Health System, PA

Poor, Alexander E.  
Drexel University School of Medicine, PA

Pucci, Michael J.  
St. Vincent's Hospital, NY

Rubino, Matthew S.  
Christiana Care, DE

Srinivasan, Svertha K.  
Emory University School of Medicine, GA

Walk, Ryan M.  
NCC-Walter Reed Army Medical Center, DC

Wolfe, Grant C.  
Palmetto Health Richland, SC

**Surgery-Preliminary**
Chitale, Rohan V.  
Thomas Jefferson University Hospital, PA

Cruz-Schiavone, Sebastian F.  
Boston University School of Medicine, MA

del Valle, Antonio L.  
Beth Israel Medical Center, NY

Dunn, Matthew A.  
Lankenau Hospital, PA

Frank, Harrison  
Wake Forest Baptist Medical Center, NC

Heckler, Adrienne M.  
Oregon Health & Science University, OR

Nguyen, Augustine D.  
Hershey Medical Center/Pennsylvania State University, PA

Panov, Fedor E.  
Mt. Sinai Hospital, NY

Politi, Roman C.G.  
Thomas Jefferson University Hospital, PA

Sackett, Daniel D.  
Thomas Jefferson University Hospital, PA

Smith, Jordana M.  
Thomas Jefferson University Hospital, PA

Stone, Marielle K.  
Loyola University Medical Center, IL

Tyson, Adam T.  
University of Connecticut Health Center, CT

Vadera, Sumeet  
Cleveland Clinic Foundation, OH

Wiepert, Eric R.  
Orlando Regional Healthcare, FL

Yeoh, Jin Soon  
State University of New York at Buffalo, NY

**Transitional**
Alabakoff, Jason  
Oral Maxillofacial Surgery Practice

Cupino, Andrew C.  
Frankford Hospitals, PA

Ergas, Heath B.  
Conemaugh Memorial Hospital, PA

Gallagher, Deirdre  
Cruzer-Chester Medical Center, PA

Hoey, Courtney L.  
Albert Einstein Medical Center, PA

Koenigsberg, Joanna B.  
Albert Einstein Medical Center, PA

**Urology**
Heckler, Adrienne M.  
Oregon Health & Science University, OR

Sackett, Daniel D.  
Thomas Jefferson University Hospital, PA

Sleeper, Joshua P.  
University of Texas-Southwestern, TX

Tyson, Adam T.  
University of Connecticut Health Center, CT

Yeoh, Jin Soon  
State University of New York at Buffalo, NY

**Other**
Anandanadesan, Rathai  
Residency Deferred

Eiszner, James R.  
Residency Pending

Lee, Na Y.  
Residency Deferred

Silver, Scott J.  
Residency Pending

**Jefferson Medical College Alumni Bulletin**
Match Day

Number of students matched March 15, 2007: **214**
Residencies deferred: **2**
Residencies pending: **2**

Number of graduates matched with Thomas Jefferson University Hospital: **46**
Who will work in Philadelphia: **85** (includes above)
In Pennsylvania: **112** (includes above)

Most popular matches
Internal Medicine: **48**
Pediatrics: **20**
Family Practice: **17**
Emergency Medicine: **16**
Radiology, diagnostic: **13**
Ophthalmology: **13**

Most popular geographical locations after Pennsylvania,
New York: **33**, Delaware: **13**, Massachusetts: **10**

Members of the class who have Jefferson alumni as relatives: **14**
Members who follow their fathers into his field: **4**
Graduate who will follow in his mother’s footsteps: **1**
Recent graduates who have a parent on the faculty: **7**

*Numbers include students who will do residencies in more than one state.*
Alumni Weekend ’07  Jefferson Medical College
September 28 – 29

Where the past and the present come together to celebrate!

Join your fellow alumni for a weekend of fun-filled activities

Alumni Banquet
CME Symposium*
Class Clinics
Programs for Children
“Taste of Philadelphia” Luncheon
Tours of the new Dorrance H. Hamilton Building
Reunion Class Dinners
Live Entertainment

Registration
Deadline for mail and online registration for events and program directory listing is September 21. Only phone registration will be available after this date.

Online
www.jefferson.edu/jmc/alumni/reunion_wknd.cfm

Mail
Formal invitation will be sent by mail with reservation form enclosed. Complete form and return with payment.

Phone
1-877-JEFF-GIFT

Questions
e-mail: events@jefferson.edu or phone number above

* The Warren P. Goldberg, MD’52, CME Program is free to alumni and faculty. For more information, please contact the JMC Office of CME: 1-888-JEFF-CME or online at http://jeffline.jefferson.edu/jeffcme/.